Great Destinations Pediatrics P.C.

PATIENT'S INFORMATION

Patient's Name_____ Sex M_____ F_____ Date of Birth_____

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Patient's Name_____ Sex M_____ F_____ Date of Birth_____

Patient's HomeAddress_____ Home Phone(_____)-_____-_____
Street City ST Zip

Marital status of child's parents (Please Check One):

PARENT'S INFORMATION Married_____ Single _____ Separated _____ Divorced _____

Please Circle (Natural, Step, Adoptive Parent, Guardian)

Mother's Name_____(**Maiden Name)**_____ SS# _____-_____-_____

HomeAddress_____ Home Phone(_____)-_____-_____
Street City ST Zip

Employer _____ Cell or Work (_____)-_____-_____ Email _____

Occupation _____ Date of Birth _____

Please Circle (Natural, Step, Adoptive Parent, Guardian)

Father's Name _____ SS # _____-_____-_____

Home Address _____ Home Phone(_____)-_____-_____
Street City ST Zip

Employer _____ Cell or Work (_____)-_____-_____ Email _____

Occupation _____ Date of Birth _____

INSURANCE INFORMATION

Primary Insurance Company Name	Name of Policy Holder	Policy/ID Number	Group Number
Secondary Insurance Company Name	Name of Policy Holder	Policy/ID Number	Group Number

Name of Nearest Relative: Name _____ Phone _____
(Not living with you)

Name _____ Phone _____

How did you hear about our practice? _____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN:

I hereby authorize payment directly from my insurance company to the physician's of Great Destinations Pediatrics for Medical treatment(s) provided to my Child.
I understand that payment in full of my responsible portion is required at the time of visit. If Great Destinations Pediatrics (GDP) is not a provider on my insurance, full payment is due on the date of service. If GDP is a provider on my insurance, then any deductibles, co-pays, or percentages are due at the time of service. Additionally, should it be necessary to assign my account for collections, it is hereby agreed that I shall pay reasonable charges, attorney's fees, and all other costs.
I hereby authorize GDP to examine and treat my child when necessary. I also authorize the release of my protected health information, acquired in the course of examination to carry out treatment, payment and heath care operations of my child.

FINANCIAL/OFFICE POLICY & HIPAA:

I have read and understand the foregoing financial and office policy and agree to abide by the terms of this policy. I also acknowledge that I have received a copy of the Notice of Privacy Practices, including Omnibus Rule.

_____ Date _____/_____/_____
Responsible Party Signature